KARNATAKA ASSOCIATION OF COMMUNITY HEALTH (Regd.)

CME AND ELEVENTH ANNUAL CONFERENCE AT KIMS

9th and 10th May 1997

Emerging Communicable Diseases : Concerns and Approaches to Control

SOUVENIR

With Best Compliments From :

Sri Devaraj Urs Educational Trust

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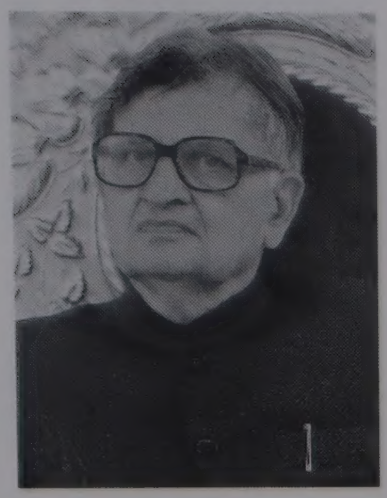
- CONTENTS -

* * *

Front Cover Designed by Mr. C.S.Gubbi based on ideas given by Mr.L.Bipinchandra Bhagath, Ms. Poonam Arya and Ms. Smitha Devaiah - (VIII term students, KIMS.)

The background colour that changes from blackish blue in the bottom to white at the top signifies moving from illhealth towards positive health, the fly and mosquito represent the disease vectors, the smoke emerging from the factories denote the problems of urbanization and industrialization and their role in disease causation.

The Mother and Child and the aged people represent the vulnarable group who have to be protected from disease and disability by providing proper and adequate health care which is represented by the symbol of health(+) and the hands signify the importance of Community participation in providing this care, all the more so in view of the very relevant WHO theme.



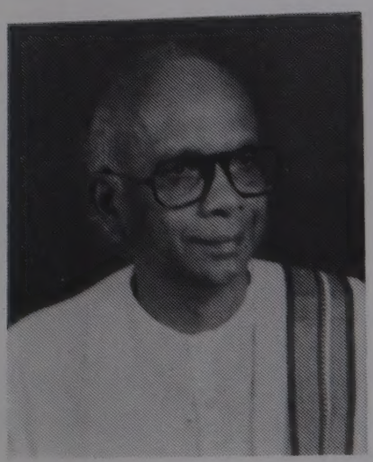
MESSAGE

I am glad to know that the Karnataka Association of Community Health is organising its eleventh annual conference on the theme "Emerging Communicable Diseases : Concern & Approaches to control" On May 09th and 10th at Kempegowda Institute of Medical Sciences.

I wish the organisers and the delegates all sucess on this happy occasion.

(KHURSHED ALAM KHAN)

GOVERNER KARNATAKA STAE



ಸಂದೇಶ

'ಕರ್ನಾಟಕ ಅಸೋಸಿಯೇಷನ್ ಆಫ್ ಕಮ್ಯುನಿಟಿ ಹೆಲ್ತ್' ಸಂಸ್ಥೆಯು ೧೧ನೇ ವಾರ್ಷಿಕ ಸಮ್ಮೇಳನವನ್ನು ಮತ್ತು ಮುಂದುವರೆದ ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ ಕುರಿತು ಶಿಬಿರವನ್ನು ಆಯೋಜಿಸಿರುವುದನ್ನು ಆರಿತು ಮಾನ್ಯ ಮುಖ್ಯ ಮಂತ್ರಿ ಶ್ರೀ ಜೆ. ಹೆಚ್. ಪಟೇಲ್ ಅವರು ಅಪಾರ ಹರ್ಷ ವ್ಯಕ್ತಪಡಿಸಿದ್ದಾರೆ.

'ಸರ್ವರಿಗೂ ಆರೋಗ್ಯ ಕಲ್ಪಿಸುವ ಹಿನ್ನೆಯಲ್ಲಿ ಇಂತಹ ಕಾರ್ಯಕ್ರಮಗಳು ಅತಿ ಹೆಚ್ಚು ಪ್ರಭಾವಶಾಲಿ ಎಂದು ತಿಳಿಸಿರುವ ಮುಖ್ಯಮಂತ್ರಿಗಳು ವಾರ್ಷಿಕ ಸಮ್ಮೇಳನ ಯಶಸ್ವಿಯಾಗಲಿ, ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ ಉದ್ದೇಶ ಪ್ರತಿಶತ ಈಡೇರುವಂತಾಗಲಿ' ಎಂದು ಶುಭ ಹಾರೈಸಿದ್ದಾರೆ.

(ಎಂ.ಎಲ್. ಶಂಕರಲಿಂಗಪ್ಪ)
ವಿಶೇಷ ಕರ್ತವ್ಯ ಅಧಿಕಾರಿ

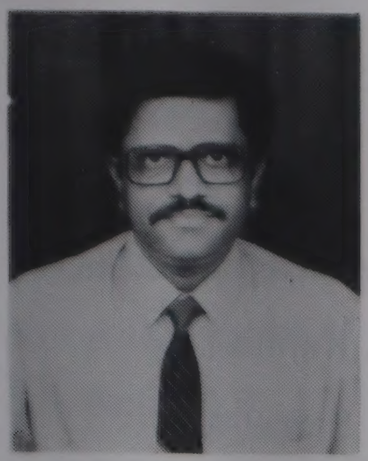
MESSAGE

I am very happy to note that Karnataka Association of Community Health is organising a Continued Medical Education Programme and holding its Eleventh Annual Conference on 9th and 10th May 1997 at Kempegowda Institute of Medical Sciences, Bangalore.

I wish the conference a brilliant sucess.

(H.C. MAHADEVAPPA)

Minister of Health Family Welfare
Government of Karnataka



FOREWORD

The Department of Community Medicine, Kempegowda Institute of Medical Sciences (KIMS), is previleged to host this eleventh annual conference of KACH together with the first CME programme. The nostalgia reminds us of the successful launching of KACH about twelve years back by KIMS on 8th June 1985. Over these eleven years both KIMS and KACH have grown from strength to strength and have occupied pivotal positions in their respective spheres.

The eleventh annual conference is planned particularly to provide a good opportunity to the PGs and Junior staff to demonstrate their scientific merit and organizational competance. The CME Programme on `Emerging commicable diseases - concerns and approaches to control is planned as an intensive and exhaustive interactive session benefitting all those participating in the process. The success of this programme would provide the necessary impetus to future organizers.

Lastly, this two days of academic deluge and scientific extravaganza has become possible for all the help, co operation, assistance from the Donors, Sponsorers, Advertisers, Speakers, Chairpersons, Delegates and the sheer hardwork and committment of the Members of Reception and Organizing committees, Student Volunteers and staff of KIMS and other colleges. I take this opportunity to thank all of them.

Dr. M.K. Sudarshan
Chairman

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May 3rd 1997

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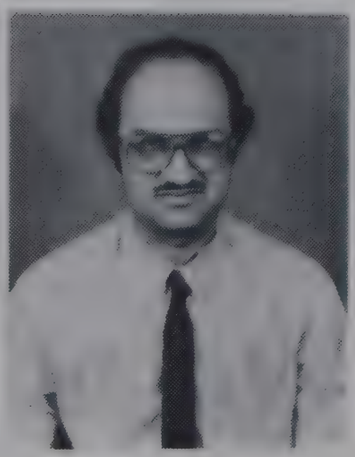

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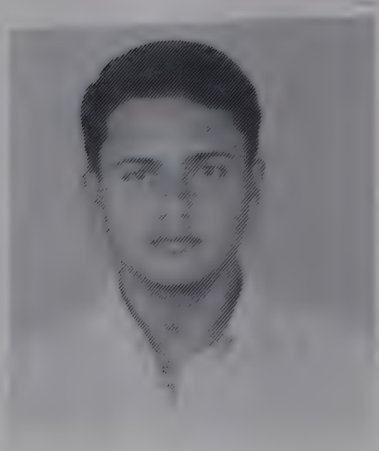

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Dr. K. Ravi Kumar, *NMEP, Regional Helath Office*
Govt. of India. Bangalore Topic: Malaria

Dr. Shyamal Biswas, *Plague Surveillance Unit,*
NICD, Bangalore Topic: Plague

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Victoria Hospital, Bangalore
Topic : Dengue & JE

Dr. Ravi *Professor,* Department of Neurovirology
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Topic : HIV and AIDS

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Topic : Immunization against VPDs

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Topic : Leprosy

Dr. Naresh Bhat, *Gastro Entertogist*, Bangalore
Topic : Hepatitis B

Dr. M.K. Sudarshan, *Prof & Hod of Community*
Medicine & Rabies Epidemiology Unit, KIMS, Bangalore - 4
Topic : Rabies

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Karnataka Association of Community Health
(KACH)

The organizing committee
cordially invites you to the Inauguration of

Continued Medical Education (CME) Programme
on
Friday, 9th May 1997 at 9 A.M.
at
Kempegowda Institute of Medical Sciences (KIMS)
Auditorium (2nd Floor), V.V. Puram, Bangalore - 4.

Dr. S. Kantha
Vice-Chancellor, Rajiv Gandhi University of Health Sciences, B'lore
has kindly consented to inaugurate the CME Programme

Dr. K.S. Shadaksharappa
Chairman, NAMS-Karnataka and Medical Education and
Research Trust, Bangalore
the chief guest, will release the souvenir.

Dr. K.M. Srinivasa Gowda
Principal, Kempegowda Institute of Medical Sciences
will preside over the function.

Dr. N. Shantaram
President, Karnataka Associatin of Community Health
will speak about KACH

Dr. M.K. Sudarshan
Cahirman, CME Programme and Eleventh Annual Conference of KACH
will speak about CME Programme.

Karnataka Association of Community Health
(KACH)

The organizing committee
cordially invites you to the

Public Awareness Programme on Emerging Communicable Diseases: Concerns and Approaches to Control (in Kannada)
on
Friday, 9th May 1997 at 6 P.M. (Evening)
at
Kempegowda Institute of Medical Sciences (KIMS)
Auditorium (2nd Floor), V.V. Puram, Bangalore - 4.

Smt. Padmavathi Gangadhar Gowda
Worshipful Mayor of Bangalore

has kindly consented to be the chief guest and
inaugurate the Programme

Dr. S.R. Bilagi DPH
Health Officer, Bangalore City Corporation

Dr. M. Maiya, FRCP
Physician, Maiya Nursing Home, Bangalore

Dr. S.R. Keshavamurthy, M.D. DNB
Prof & HOD of Paediatrics and President, IAP Bangalore

Dr. M.S. Rajanna, M.D.
Professor of Community Medicine, KIMS

will participate and address the gathering.

Karnataka Association of Community Health
(KACH)

The organizing committee
cordially invites you to the inauguration of

Eleventh Annual Conference of KACH
on
Saturday, 10th May 1997 at 9 A.M.
at
Kempegowda Institute of Medical Sciences (KIMS)
Auditorium (2nd Floor), V.V. Puram, Bangalore - 4.

Dr. (Capt.) V.G. Shetty
Director of Health and Family Welfare Services, Govt. of Karnataka, Bangalore.
has kindly consented to inaugurate the conference

Dr. N. Shantaram
President, Karnataka Association of Community Health
will preside over the function

Dr. K. Basappa
Sr. Professor of Community Medicine, AIMS, Bellur
will receive the best Community Health Professional Award

Dr. K.M. Srinivasa Gowda
Principal, Kempegowda Institute of Medical Sciences
will grace the occassion

Dr. A.N. Arumugam
Sr. Professor of Community Medicine, SDUMC, Kolar
will release the Journal

Dr. B.G. Parasuramalu
Professor of Community Medicine, KIMS
will speak about the Conference.

Karnataka Association of Community Health (Regd.)

National Academy of Medical Sciences (India), Medical Education Research Turst, Bangalore

Continued Medical Education (CME) Programme & XI Annual Conference at KIMS, Bangalore-4

THEME

Emerging Communicable Diseases: Concerns and Approaches to Control

ORGANIZATION AND VENUE

Department of Community Medicine
Kempegowda Institute of Medical Sciences
Bangalore-560 004.

PROGRAMME SCHEDULE

Friday, 9th May, 1997

SESSION - I : CME PROGRAMME

Programme Coordinator	:	**Dr. M.S. Rajanna**, Professor of Community Medicine, KIMS, Bangalore
08-00 – 09-00 a.m.	:	Registration of Delegates, Reception of Special Invitees & Guests of Honour.
09-00 – 10-00 a.m.	:	**INAUGURAL FUNCTION** **Dr. S. Kantha** *Vice Chancellor, Rajiv Gandhi University of Health Sciences* **Dr. K.S. Shadaksharappa** *Chairman, MERT (Release of Souvenir)* **Dr. K.M. Sreenivasa Gowda** *Principal, KIMS*
10-00 – 10-30 a.m.	:	TEA

10-30 – 11-15 a.m. : **TUBERCULOSIS – Present Status and Newer Strategies for Control**

Speaker: **Dr. Satish**,
Chest Specialist,
Wockhardt Hospital, Bangalore

Chairman: **Dr. Vishveshwaraiah,**
Joint Director (Rtd.), Tuberculosis

11-15 – 12-00 noon : **MALARIA – Resurgence and Approaches to Treatment and Control**

Speaker: **Dr. K. Ravikumar,**
NMEP, Regional Health Office, Govt. of India, Bangalore

Chairman: **Dr. P.N. Halagi,**
Addl. Director, Bangalore

12-00 – 12-20 p.m. : **PLAGUE – 1994 Epidemic in India, Summary Report**

Speaker: **Dr. Shyamal Biswas,**
Plague Surveillance Unit, NICD, Bangalore

Chairman: **Dr. S.B. Kurthkoti,**
Addil. Director (CMD),
Govt. of Karnataka, Bangalore-9

12-20 – 12-50 p.m. : **DENGUE & JAPANESE ENCEPHALITIS – Current Scenario & Approaches to Control**

Speaker: **Dr. N.Y. Prasanna,**
NIV Unit, ICMR, Victoria Hospital, Bangalore

Chairman: **Dr. S.B. Kurthkoti**,
Addl, Dirctor (Communicable Diseases),
Govt. of Karnataka, Bangalore-9

12-50 – 01-30 p.m. : **HIV & AIDS – Current Scenario and Future Prospects of Control**

Speaker: **Dr. Ravi,**
Professor, Dept. of Neurovirology,
Nimhans, Bangalore

Chairman: **Dr. Mohammed Shaukat,**
NACO, New Delhi

01-30 – 02-15 p.m. : LUNCH

02-15 – 3-00 p.m. : **IMMUNIZATIONS AGAINST VACCINE PREVENTABLE DISEASES – Indian Scenario & Future trends**

Speaker: **Dr. K. Suresh,**
Project Officer,
UNICEF, New Delhi-3

Chairman: **Dr. C. Shivaram,**
Principal,
MSRMC, Bangalore-54

03-00 – 03-45 p.m : **LEPROSY – Progress Towards Eradication**

Speaker: **Dr. M.T. Hema Reddy,**
Director, H & F.W. Training Centre,
Govt. of Karnataka, Bangalore

Chairman: **Dr. M.S. Neelakantha Rao,**
WHO Consultant, Bangalore

03-45 – 04-00 p.m. : TEA

04-00 – 04-30 p.m. : **HEPATITIS B & ITS PREVENTION**

Speaker: **Dr. Naresh Bhat,**
Gastro Enterologist, Bangalore

Chairman: **Dr. M. Maiya,**
Maiya Nursing Home, Bangalore

04-30 – 05-00 p.m. : **RABIES & ITS PREVENTION**

Speaker: **Dr. M.K. Sudarshan,**
Prof. & HOD of Community Medicine &
Rabies Epidemiology Unit, KIMS,
Bangalore

Chairman: **Dr. S.N. Madhusudana,**
Dept. of Neurovirology, NIMHANS,
Bangalore

05-00 – 05-15 p.m. : VOTE OF THANKS – **Dr. M.S. Rajanna**

SESSION - II: PUBLIC AWARENESS PROGRAMME

(in Kannada)

05-15 – 05-45 p.m.	:	TEA
06-00 – 07-00 p.m.	:	**EMERGING COMMUNICABLE DISEASES – Concerns, Approaches to Prevention, Treatment and Control**
Inauguration	:	Worshipful Mayor **Smt. Padmavathi Gangadhara Gowda**
Panel Discussion	:	**Dr. M. Maiya**, *Physician, Bangalore*
		Dr. S.R. Bilagi, *Health Officer, BCC, Bangalore*
		Dr. M.S. Rajanna, *Professor of Community Medicine, KIMS, Bangalore (Moderator)*
		Dr. S.R. Keshava Murthy, *Prof. & HOD of Paediatrics, President, IAP, Bangalore*
08-00 p.m.	:	DINNER

SATURDAY 10TH MAY 1997

Eleventh Annual Conference of KACH

09-00 – 10-00 a.m.	:	INAUGURAL FUNCTION:	
		Inauguration:	**Dr. (Capt.) V.G. Shetty,** *Director of Health & FW Services, Govt. of Karnataka, Bangalore*
		About KACH & Award	**Dr. N. Shantaram,** *President, KACH.*
		Award of KACH to Best Community Health Professional	**Dr. K. Basappa** *Ex. President, KACH, Retd. Prof. HOD of PSM from BMC & MSRMC*
		Release of Journal	**Dr. A.N. Arumugam,** *Sr. Professor of Community Medicine SDUMC, Kolar*
10-30 – 11-00 a.m.		TEA	

SESSION - III : FREE PAPERS PRESENTATION

11-00 – 12-30 p.m. : Chief Coordinator: **Dr. K.N. Prasad**
Asst. Professor of Community Medicine, KIMS, Bangalore-4

HALL - I (AUDITORIUM) Thematic Papers (Staff)

Chairman: **Dr.**

Rapporteur: **Dr.**

Coordinator: **Dr. K. Rohit**

HALL - II (COMM. MED. SEMINAR HALL) Free Papers (Staff)

Chairman: **Dr.**

Rapporteur: **Dr.**

Coordinator: **Dr. M. Jayakumary**

HALL - III (KIMS AV ROOM) Thematic & Free Papers – PGs, Interns & Students

Chairman: **Dr.**

Rapporteur: **Dr.**

Coordinator: **Dr.**

SESSION - IV

11-00 – 12-30 p.m. : **POSTER PRESENTATION & EXHIBITION**
[KIMS Lecture - Hall-II]

Coordinator: **Dr. B.J. Mahendra,**
Lecturer, Dept. of Community Medicine, KIMS, Bangalore-4

12-30 – 01-00 p.m. : **VALEDICTORY FUNCTION – Dr. Gangaboriah**
Asst. Professor of Statistics, KIMS, Bangalore - 4

01-00 – 02-00 p.m. : LUNCH

02-00 p.m. : Annual General Body Meeting
Convenor: **Dr. G.V. Niranjan,**
Secretary, KACH

: TEA

KIMS- Department of Community Medicine
"A Profile and Glimpses of Achievements"

HISTORY

The Department was started on April 1, 1981 with Dr. M.K. Sudarshan as Lecturer and incharge of the department and later Dr. A.N. Arumugam joined as Professor and Head in December 1982. Since then the department has always remained in the forefront and is known for its active role and major initiatives in the Institution. The staff who are key to this success have contributed individually and collectively.

The present **staff** are as follows.

1.	Dr. M.K. Sudarshan, MD [BHU]	-	Professor and Head
2.	Dr. B.G. Parasuramalu, MD	-	Professor
3.	Dr. M.S. Rajanna, MD	-	Professor
4.	Dr. Gangaboraiah, PhD	-	Asst. Professor of Statistics
5.	Dr. M.Sundar, MD	-	Asst. Professor
6.	Dr. K.N. Prasad, MD, DNB	-	Asst. Professor
7.	Dr. B.J. Mahendra MD	-	Lecturer
8.	Shashikala Manjunath, MD, DIH	-	Lecturer
9.	Dr. D.H. Ashwathanarayana, MBBS	-	Tutor cum PG student (MD)
10.	Dr. R.K. Prasad, MBBS	-	Tutor
11.	Mr. Dharmaraj, MA, MSW	-	Medico Social Worker
12.	Mr. M.K. Chandrashekar, MA, LLB, DNHE	-	Health Educator.
13.	Mrs. Giriji Narayan, MA	-	Medico-Social Worker
14.	Mr. Nateshan	-	Driver
15.	Mr. T. Ramakrishna	-	Driver
16.	Mr. Lingaraju	-	Driver
17.	Mr. Shivanna	-	Attender
18.	Mr. M.C. Muddegowda	-	Attender
19.	Mr. Thimmegowda	-	RHTC Watchman
20.	Mr. Hanumanthegowda	-	Attender
21.	Mr. Somashekar	-	Attender

PG Students (MD)

22.	Dr. M. Jayakumary, MBBS	-	1994-97
23.	Dr. K. Rohit, MBBS,	-	1996-99
24.	Dr. D.H. Ashawathanarayana, MBBS	-	1996-99

ROUTINE ACTIVITIES

The department is doing the following activities routinely.

- Lectures, Practicals, Tutorials, Field and Institutional Visits to undergraduate MBBS students.
- Subject seminars, Topic presentations are arranged to encourage their active participation in learning process.
- Supervisory rural internship training is conducted at RHTC, Kengeri.
- MD students, besides thesis work, are encouraged to present papers in State and National Conferences.
- PG students are posted for training to both Government of Karnataka and Govt. of India Institutions like Public Health Institute, BCC Health Department, Indian Institute of Management, NIPCCD, NICD etc.

The department is fully equipped with audio - visual aids viz. TV, VCR, OHPs, ASPs, PAS, etc, and has a well furnished seminar hall which also serves as a hall of CME programmes of the Institution.

SERVICES

The department in a unique way is providing the following services also:

- Immunization to women and children under National Immunization Programme in the OPDs of Jayanagar General Hospital (JGH) and KIMS Hospital.
- ARV treatment at JGH and ARS at KIMSH
- Allergy Centre at KIMS Hospital
- PACE [Prevention of AIDS through Community Education].
- CME Programmes on Rabies, AIDS, etc., to Medical Professional Associations, Colleges, Schools, Lay Audience, AIR & Doordarshan Programmes.
- Rural Health Camps, Participation in National Health Programmes viz., Good-bye Polio, Pulse Polio etc.

IMPORTANT ASSIGNMENTS

The department has under taken the following important assignments.

- Conducted Pioneer Diarrhoeal disease survey in Kaveri river basin of Karnatak region, Government of India (1991)
- UIP training centre for Medical Officers of Bangalore (1985-90)
- Technical Assistance to DANIDA National blindness control programme, UNICEF National Immunization Programme, USAID PVOH-II Projects of Government of India.
- The only department (of Medical Colleges) to participate in **Plague Epidemic Control** in Bangalore at Edpidemic disease hospital, in October 1994.

KEY ACHIEVEMENTS

The department has been successful in achieving the following.

- Launch of Karnataka Association of Community Health a State level Public Health Association, in June 1985 at KIMS.
- Regional training centre for the Distance learning programme of Health & Family Welfare Management for Medical Officers of South India for the National Institute of Health and Family Welfare (NIHFW) New Delhi, Since 1993.
- Editorial Office for Karnataka Journal of Community Health (1985-1993) and Indian Journal of Community Health (1995 onwards)
- Kannada Vaidya Sahithya Parishath
- Programme study centre for Karnataka and Goa region of IGNOU (Government of India) for Postgraduate Diploma in Maternal and Child Health [DMCH] for Medical Officers (1997 onwards)
- Placement Training Centre for Indian Institute of Health Management Research (IIHMR) PG Diploma in Health & Hospital Management [PGDHM] Course [1997 onwards]

MAJOR RESEARCH PROJECTS

The Department has undertaken the following research projects

- WHO funded project on Health Systems Research (1993)
- PMSV, Lyon, France funded project on Anti - rabic vaccine trails, Typhim, Vi; SII, Pune on PCEC (Japan) Vaccine, Phase III trial; Hoechst study on Typhoid Vaccine.
- KSCST, Government of Karnataka funded projects on Rabies, Cold Chain, AIDS, and Allergy.

ACADEMIC ACTIVITIES

The department is engaged in the following Academic activities.

- MD Course Since 1992 MCI approved
- Ph D Course (Part- time)
- Many workshops, seminars viz., state level and regional level conducted for Medical and Paramedical Personnel.
- WHO and AIDS days observed regularly every year.
- CME on Infections Disease and Medical Statistics for PGs and Junior teacher of Medical Colleges.
- Epidemiological and Statistical guidance to PGs and teachers of other disciples in our College and researchers from various other Institutions.
- Teaching assignments to Dental and Nursing students.

PERSONAL ACCOMPLISHMENTS

The following are some of the personal accomplishments of the staff while in service in the department.

1. Dr. M.K. Sudarshan, Professor and HOD represented India at WHO symposium on Rabies (Jakarta & Bali, Indonesia, 1993); Participated in the Environmental Epidemiology workshop at Switzerland (1993); Symposium on Vaccines at Paris, France (1995) Third International Symposium on Rabies Control, Wuhan China (1996)

2. Dr. Gangaboraiah, Asst. Professor of Statistics, was awarded Ph D in Statistics from Bangalore University for his thesis A Study of Some Stochastic Models of Carcinogenesis and their Statistical Analysis, in 1996.

PUBLICATIONS

The faculty of the department have published over 30 papers in various national and regional journals. Books in Kannada on Rabies Sponsored by Government of Karnataka, Mother and Child Health and other related issues are published.

HEADS OF DEPT & TENURE

1.	Dr. M.K. Sudarshan, MD (BHU)	-	1981-82
2.	Dr. A.N. Arumugam, MD, DPH	-	1982-88
3.	Dr. M.K. Sudarshan, MD (BHU)	-	1989 till date

OBITUARIES

1.	Dr. D.P. Narasimha Murthy, Professor	1989
2.	Mr. Rajanna, RHTC Watchman	1989

RABIES EPIDEMIOLOGY & INFORMATION CELL

The department through its P& SM units in JG Hospital (AR Vaccine)& KIMS Hospital (Anti - Rabic Serum) is providing specialist anti-rabic treatment services. The unit is popular in Bangalore City and all doubtful cases are referred for final opinion. The units are under the technical supervision of Dr. M.K. Sudarshan, who is trained at CRI, Kasauli & Pasteur Institute, Coonoor and has represented India as Official Country representative to WHO Symposium on Rabies in 1993 at Jakarta / Bali, Indonesia and at Taiwan, China in 1996; Participated in the International Symposium on vaccines, at Pasteur Institute, Paris in 1995. The unit is engaged in CME programmes for Medical personnel throughout Karnataka, has conducted 2 (PVRV & PCEC) ARV Trails, other studies and has publications viz., book, articles, Pamphlets, etc & TV & Akashvani Programmes to its Credit.

PAGER SERVICES FOR FREE PROFESSIONAL GUIDANCE

To commemorate the year of vaccines, 1996 and on the occasion of 101 years after Louis Pasteur, on 28th September, 1996 a novel and unique Pager Services was launched in India in Bangalore city for guiding Medical and Veterinary professionals for proper rabies prophylaxis. The **Pager No. is 9624-243410** and is sponsored by Pasteur Merieux Serums & Vaccins, New Delhi.

ALLERGY CENTRE, P& SM UNIT, KIMS HOSPITAL

The department through its P & SM unit in KIMS Hospital is conducting Allergy test for Naso - Branchial Allergy patients & prescribing immunotherapy. This centre is popular in Bangalore City and the patients are referred from E.N.T. Medicine Paediatrics & other clinical Departments of KIMS Hospital, Jayanagar General Hospital & also from some private practitioners in and around Bangalore City. The Centre is under the Technical supervision of Dr. B.G Parasuramalu, who is trained by Indian Academy of Allergy. This centre has carried out some studies like '' Clinico-epidemiological study of Naso - bronchial Allergy in Bangalore City'', which bagged the best paper award at the state conference held at Mysore. The unit proposes to study the problem of allergy in Bangalore City and as a first step a KSCST funded MD thesis is in progress.

PACE: PREVENTING AIDS THROUGH COMMUNITY EDUCATION

The pace group was formed in 1992 which consists of medical students both boys and girls. This is an unique initiative among 18 medical colleges in Karnataka. This active group strive hard to impart information and envisage behavioural change among medical students and lay people.

PACE group activities are manifold such as conducting AIDS awareness programmes in schools and colleges; organizing world AIDS day every year; arranging competitions in schools and colleges on AIDS. PACE has prepared its own audiovisual aids and established linkages with other organisations,

Besides various research studies on AIDS have been conducted and funded by KSCST, IISc. Bangalore. HIV/AIDS counselling is done to victims and has formulated policy for HIV/AIDS management in KIMS Hospital. It is proposed to launch sex education and AIDS awareness in colleges and schools in a bigger way. All these have been done under the leadership and initiative of Dr M. Sundar, Assistant Professor of Community Medicine.

PULSE IUD PROGRAMME (PIP)

OPERATIONAL GUIDELINES:

1. SITUATION ANALYSIS:

1.1: Family Planning Programme (renamed as Family Welfare 1978) has had a single objective for nearly 30 years to reduce fertility as quickly as possible. The programme has sought to achieve this goal through a strategy based on contraceptive targets and cash incentives to acceptors and providers.

The objective of the Family Planning Programme is to reduce the birth rate. Contraception is only an instrument for bringing about the reduction in birth rate.

The success of the programme with reference to the objective can be judged only on the basis of the reduction in the birth rate.

As a result of implementation of this programme, tangible results have been achieved as revealed by the following vital indicators in Karnataka State.

Indicator	1970	1995
Crude Birth Rate	33.0	24.2
Infant Mortality Rate	101.0	62.0

However the decline in crude birth rate by 8.8 only in 25 years has been considered as very slow as compared to neighbouring states - Kerala and Tamil Nadu.

1.2: Analysis in contraceptive practice has indicated disproportionate percentages in method mix as follows:

Method	1991-92	1995-96	%
1. Sterilization	40.0	44.96	79
2. I.U.D.	6.1	7.69	14
3. OP Users	1.8	2.35	4
4. C.C. Users	1.2	1.91	3
Total	49.1	56.91	100

Nearly 80% of the contraceptive practice is contributed by sterilisation alone. 98% female and mere 20% by spacing methods (out of which 14% by IUD).

Courtesy: Dr. G.V. Nagaraj, MD,DPH,PGDHM, Additional Director (FW) SFWB, Bangalore-9

1.3: Inspite of performance to the extent of 94-95, percent every year under sterilization requiring lot of inputs of resources with various constraints, birth rate in Karnataka continue to remain high since the practice of spacing methods has been very low. Numerous field studies have indicated that spacing methods will bring down birth rate faster than sterilization.

1.4: The National Health Survey (1992-93) has revealed two important features regarding the practice of family planning in the state.

i) I.U.D.: (Copper 'T') is more prevalent among Muslims (6%), among Hindus (3%) and Christians (1%).

ii) 18% of currently married women have an unmet need for family planning, 12% for spacing births and 6% for limiting number of births. These women are not using family planning eventhough they do not want any more children or want to wait at least two years before having another child.

The previous paragraphs indicate that there is an urgent need to promote spacing methods in the state to bring down the birth rate at a faster rate than the present.

2. THE TRAIL:

2.1: Having realised the importance of spacing methods and encouraged with the tremendous response of the 1st year Pulse Polio Immunization Programme in December 1995, all the Districts were requested to implement Pulse IUD Programme on March 14th and 15th 1995. Reports received from the Districts indicated that about 39,000 IUDs were inserted on these 2 days. This was reflected in the monthly reports sent to the Government of India and Karnataka stood 4th Place in IUD at National Level during 94-95.

2.2: Again a State wide Pulse IUD Programme was launched on 10th October 1996 and about 40,000 IUDs were inserted. At the end of October 1996, Karnataka state has been placed in No. 1 position in IUD registering +15% performance as compared to last year.

2.3: Age of the wife and children wise analysis of 21,000 clients has revealed that about 90% of them are having 2 and less children and about 94% are aged 30 years and less indicating a good quality of the programme.

2.4: For the first time in the country, these 2 trials conducted in our State without much publicity campaigns have shown beyond doubt that this strategy is most appropriate which can be repeated, every 6 months to enhance not only the spacing component in contraceptive prevalance but also to bring down birth rate of 20 by 2002 A.D.

3. PULSE IUD PROGRAMME (PIP)

3.1 What is Pulse IUD Programme?

The Pulse IUD Programme is a simultaneous mass insertion of Copper 'T' to eligible married women to prevent unwanted pregnancies. This programme is to be implemented in the entire state twice in a year during the Peak Demand Period.

3.2 Pulse IUD Programme days: (PIP Days)

It is reported that the months of October and March are Peak Demand months for contraceptive

acceptance. Hence it is decided to hold PIP days every year in the months of March and october. The following dates have been identified as PIP days during 1997.

March - 13th & 14th

October - 8th & 9th

3.3. Objectives:

The objectives of Pulse IUD programme are as follows:

1. To promote spacing methods.
2. To prevent the unwanted pregnancies.
3. To bring down the unmet need particularly in spacing methods.
4. To meet the demand for small family norm and provide the required and timely service.
5. To improve mothers health and bring down infant mortality rate and improve the child survival.
6. To convert this programme into a more dynamic and popular programme than the present female sterlisation.
7. To bring in a positive change in the attitude for promotion of spacing methods and enhance skills in the insertion of IUDs by the Health personnel so that IUD services are made easily available to the women in the right time.

3.4: Copper 'T' IUDs:

3.4.1: It is an intrauterine device shaped in the form of the English Alphabet "I" and is made from polyethylene. The device has a coil of fine pure copper wrapped around its vertical arm. The presence of copper exerts a potent antifertility effect and also prevent implantation of the fertilized egg.

3.4.2: Copper 'T' is a very convenient method for spacing of birth with a 4 to 5 years interval. In order to keep its efficiency level at the optimum it can be repalced with new copper 'T', if long protection is desired. Copper 'T' is thus a convenient method.

3.4.3: ICMR has recommended Copper 'T' 200B for useage under National Family Welfare Programme in our country.

3.4.4: It has been accepted in the National Family Welfare Programme as a convenient method. It is an ideal contraceptive for young mothers. Easy, reliable and reversible.

3.4.5: The safest and best time for Copper 'T' insertion is on the day of stopage of menstruation or shortly thereafter.

4. ACTION PLAN:

4.1: State Level:

⇨ All the Divisional Joint Directors, District Health and Family welfare officers, District Surgeons, Superintendents of Major Hospitals, Heads of Voluntry Organizations will be requested for effective implementation of the programme.

- ⇨ A Meeting of District Nursing Supervisors, Principals of ANM training centres, LHV training schools will be convened in the month of Febraury.
- ⇨ A meeting of District family planning officer will be convened in the first week of March 1997.
- ⇨ An appeal will be given by the Health Secretary to all the Divisional Commissioners, Deputy Commissioners and Chief Executive Officers of Zilla Panchayats.
- ⇨ Hon'ble Health Minister's message will be Telecast in Doordarshan and a talk through All India Radio.
- ⇨ Posters will be printed and distributed to all the districts.
- ⇨ A single sheeter on Pulse IUD will be printed and distributed to all the districts.
- ⇨ Hoardings will be erected at prominent places.
- ⇨ Press advertisement will be given in all leading newspapers one day prior to the PIP day.
- ⇨ A press meet will be held by the Hon'ble Health Minister.
- ⇨ Budget will be released to the District Health and Family Welfare Officers through D.J.Ds towards counselling and motivation of the clients.

4.2: District and Down below:

A meeting in the last week of February is to be convened under the Chairmanship of Deputy Commissioner/Chief Executive Officer to formulate the action plan for holding PIP on 13th & 14th March 1997. The District Pulse Polio Co-ordination Committee may be used for this.

PIP action plan is to be discussed in the monthly meeting to be held at the District Level and PHC level.

Institution wise health personnel available such as Medical Officer, LHV, ANM is to be indentified by name who will provide IUD insertion services.

The ANM who has under-gone crash training is competent to insert IUD and she will first cover her sub-centre area and then provide the required service for the clients of neighbouring sub-centre area if services are not available by the concerned ANM.

4.2.1: Environment Building:

The Health Functionaries and supervisors, during the visit of the villages should contact the women members of Gram panchayat, members of Mahila Swasthya Sangha and also opinion leaders of the villages to strengthen the interpersonal communication. They must also be involved in appropriate counselling and motivating of the clients particularly young mothers for accepting Copper 'T'.

MEM activites are to be implemented one week prior to the PIP days.

Messages, articles and advertisements may be put up in local newpapers and All India Radio.

Mahila Swasthya Sangha members have to be involved to intensify interpersonal communication. The PIP days should be made well known to the community and free service available in all the Health Institutions.

4.2.2: Planning the Sessions:

All the PHCs, CHCs, Taluk Hospitals, Post patrum centres of Medical Colleges and District Hospitals, Urban Family Welfare Centres, Maternity Hospitals run by Corporations and Institutions run by the NGOs such as the FPAI, LIONS, IRCS etc., should be identified and listed.

IUD insertion sessions should be held in all the institutions along with mother and child protection sessions. The Pulse IUD programme day is falling on Thursday and Friday which happens to be routine immunization days in all the institutions. This opportunity should be fully made use of.

The instruments and accessories required for the IUD insertion should be kept ready in all the identified institutions including the Sub-centres.

Kit-G(IUD Kit) supplied under CSSM Programme by the UNICEF for the FRUs are to be used during the campaign.

Adequate Copper 'T' are to be procured so that there will be no shortage to meet the demand.

All the Para medical personnel such as ANMs and LHVs should be made aware of the contraindications and also selection criteria for IUD clients. The contraindications are **severe anaemia, pelvic infection, excessive or irregular bleeding, prolapse of uterus, fibroid, cancerous condition of cervix, pregnancy, Recent caeserean and erosion of cervix.**

Adequate water and washing facilities may be kept ready.

Strict cleanliness has to be ensured by clean hand washing, boiling and wearing of gloves.

A check list will be administered by the ANMs LHVs to screen and counsel every client before actual insertion of IUD. (They are expected only to ask the client to arrive at the fitness. They need not fill the check list for every client).

IUD insertion sessions should be held along with immunisation sessions from 9.00 a.m. to 4.00 p.m. on both the days i.e., 13th and 14th March, 1997.

IUD should be inserted in the sub-centres only in the rural areas. Wherever buildings are not available, the clients should be taken to nearest Health Institutions and for this Gram panchayats should be contacted to get the required accomadation. On no account IUD should be inserted in the Client's house. Temporary arrangements may be sought from the local community to provide Schools or Panchayat Office, etc.

The Deputy Commissioners and Chief Executive Officers will provide the required mobility support.

Quality of service should not be compromised at any cost.

A team of specialists at each District level should be identified along with a vehicle to meet any emergency situations during these two days.

5. ESTIMATED LEVEL OF ACCEPTANCE: (ELA)

Based on the couples for unmet need for spacing methods, the estimated level of acceptance has been worked out by the districts. The District wise additional demand has been estimated. (See Annexure 1).

6. FOLLOW UP:

All the clients who have accepted IUD insertion must be followed.

First vistit within a week

Second visit soon after the first menustration

Third visit as demanded and required

7. MONITORING:

The District Health and Family Welfare Officer will be overall incharge of the District for planning and implementation of the programme.

The District Family Planning Officer will be responsible for overall supervision of the Programme.

Each Taluk will be supervised by the concerned Taluk Health Officer. He is not only responsible for supervision of the Programme but also collecting the progress reports and expediting them to the District Health and Family Welfare Officer or District Family Planning Officer.

The performance figures should be sent through the format as per Religion, Para and Age of the wife (for 13th and 14th March sessions separately) to Demographer, Directorate of Health & Family Welfare Services.

The Statistical Assistant and District Nursing Supervisor are exclusively responsible to collect the information & send the same to the Directorate. The figures should not be included in the routine performance reports.

8. EVALUATION:

The Population Centre, Bangalore will conduct an evaluation study in the months of April-May, 1997 to assess the retention rate of the IUDs and also to learn lessons for future campaign.

ANNEXURE - 1

STATEMENT SHOWING THE ESTIMATED LEVEL OF ACCEPTANCE FOR IUD, DURING PULSE IUD PROGRAMME ON 13 & 14TH MARCH 1997

Sl. No.	Institution	No of Cu-T to be Inserted
1.	B.C.C.	4,500
	Bangalore (urban)	1,000
	Total	5,500
2.	Bangalore (Rural)	2,000
3.	Kolar	2,500
4.	Tumkur	2,500
5.	Chitrdurga	2,300
6.	Shimoga	1,500
	Bangalore Division	16,300
7.	Belgaum	4,000
8.	Bijapur	3,000
9.	Dharwad	4,100
10.	Uttar Kannada	1,200
	Belgaum Division	12,300
11.	Bellary	2,000
12.	Bidar	2,000
13.	Gulbarga	3,500
14.	Raichur	2,000
	Gulbarga Division	9,500
15.	Mysore	4,000
16.	Mandya	2,000
17.	Kodagu	400
18.	Dak. Kannada	2,800
19.	Hassan	1,500
20.	Chickmangalur	1,200
	Mysore Division	11,900
	State Total	50,000

These numbers have been arived on the basis of remaining couples for spacing methods.

STATEMENT SHOWING THE ACCEPTORS OF IUD, DURING PULSE IUD PROGRAMME ON 13TH AND 14TH MARCH 1997

Sl. No.	Institution	Inserted
1.	B.C.C. Bangalore (Urban)	4,178
2.	Bangalore (Rural)	2,393
3.	Kolar	2,452
4.	Tumkur	2,012
5.	Chitradurga	1,732
6.	Shimoga	1,400
	Bangalore Division	14,167
7.	Belgaum	4,753
8.	Bijapur	3,787
9.	Dharwad	4050
10.	Uttara Kannada	1,240
	Belgaum Division	13,830
11.	Bellary	1,505
12.	Bidar	821
13.	Gulbarga	2,139
14.	Raichur	3,302
	Gulbarga Division	7,767
15.	Mysore	3,345
16.	Mandya	1,400
17.	Kodagu	699
18.	D. Kannada	2,108
19.	Hassan	1,300
20.	Chickamangalur	886
	Mysore Division	9,738
	State Total	45,502

UNDER PULSE IUD PROGRAMME TOTAL NUMBER OF COPPER-T INSERTED IN 18 DISTRICTS WERE 43,323

According Religion:		
Hindus	-	82.8%
Muslims	-	1.4%
Chritians	-	2.5%
others	-	3.3%
According to number of children		
1. Child	-	53.5%
2. Children	-	36.5%
3. Children & more	-	10.0%
According to age:		
Less than 25 years	-	67.1%
25 - 30 years	-	27.9%
39 years & above	-	50%

Karnataka: State Level Workshop on Reproductive and Child Health (RCH) a Brief Report

Y. Chandra Shekhar[+] and N. Shantaram[++]

A State level workshop on RCH was held on 14th March, 1997 at Sri Devaraj Urs Medical college, Kolar, Karnataka, Organized jointly by the Karnataka Association of Community Health (KACH) and Department of Community Medicine, Sri Devaraj Urs Medical College. The aim of the workshop was to sensitise the participants to the challenges ahead for implementation of RCH programmes and to arrive at ways and means of achieving an acceptable level of health and development of women and children.

The participants (70) included faculty members from medical colleges of the state (30), the administrative and executive officers of health and family welfare department (20), women and child welfare department (5), Non-governmental organizations (5) & others (10). The methodology adopted was lead lectures by programme officers, subject experts, group discussions, other interactive sessions involving presentations, sharing of experiences and open house discussion.

(1) The Key issues identified in women and child health were:

There exists a vicious cycle of poor reproductive health (especially in females) leading to maternal undernutrition, poor health and survival (high IMR) and hence the belief that more number of hands (especially on the land) would translate into more income for the family. Therefore, there is low/no motivation for restricting family size (especially among the illiterate, ignorant villagers and tribals in the remote areas).

Timely informal education for the females (especially adolescents) about sexuality and reproductive hygiene, empowerment by way of economic independence, formation of women's groups, introduction of change agents and evolving a mass movement. The non-governmental organizations (NGOs) can play a pivotal role for enabling the women.

The Three E's- Education, Empowerment and Enabling of women would be the remedies for breaking the vicious cycle of poor health status and poor reproductive health among the families.

The main issues in child and adolescent health, identified were: the isolation and feeling of shame around menarche, low awareness of health problems especially, regarding STD./AIDS and drug abuse; the child marriages, and a high dropout rate (from school) among girls. Remedy suggested for problems of women and children was counselling for elders and decision makers. Also in the decision making, entire family should take part for a sustained action pattern to evolve.

[+]*Vice-President & Chairman, Scientific Committee (KACH) & Professor of Community Medicine*

[++]*President, Karnataka Association of Community Health and Professor and Head, Department of Community Medicine, Sri Devaraj Urs Medical College, Tamaka, Kolar, Karnataka State-563101.*

- For the high maternal and infant mortality rates, unsafe abortions and lack of skilled intranatal and postnatal care are also important factors. Hence the facilities existing for prenatal diagnosis, safe abortion and in order to reduce maternal and IMR etc., should be given wide publicity.

(2) The main recommendations for effective implementation of National Family welfare Programme (towards RCH), were:

I. Technical and operational Aspects:

i) The method - specific targets/incentives should be replaced by client - centred performance measures, in a phased manner.

ii) To overcome limited contraceptive choice, - widening 'cafeteria' approach: including No scalpel vasectomy'.

iii) The social marketing should be revamped:
- by reviewing incentives for commercial private sector participants;
- by broadening product range-e.g.., introduction of oral contraceptives;
- by expanding market subsidies, especially in rural areas;
- by strengthening programme management.

iv) The coverage of reproductive and child health services should be enhanced with good quality care by client - need based approach. The essential components are:

- Prevention and management of unwanted pregnancy, for which clear guidelines should be issued by the Government of India (Ministry of Health and Family Welfare) regarding service, referral, training and IEC activities.

- Facilities for MTP, at subcentre and PHC. level;

- Upgrading and equipping PHC/CHC/FRU. for ensuring safe deliveries and encouraging the expectant women to undergo institutional deliveries especially in remote areas.

- Improved IEC, detection and referral at subcentre level, improved management of referrals, TB treatment, screening for syphilis at PHC. levels.

- The FRU eg., taluk hospital or Community Health Centre CHC) should be equipped with adequate equipments and other supplies.

v) To improve child survival, management of ARI and Diarrhoeal diseases Asphyxia and LBW to be done at all levels efficiently.

vi) To improve access for the women and children to public sector services, there should be:

- reduction in the paperwork for HW's
- increased client contact time (as per one study by IIM., Bangalore - only 1/3rd of the time is spent on this.

- expansion of "link worker" scheme.
- the population/HW (F) to be not more than 1: 5000 by restricting the area and hiring more HWs (F).

vii) The referral system should be streamlined:

- by training the field staff in recognizing the referral needs.
- expanding the FRU network, and
- strengthening the role of PHC. in referral system

viii) NGO's role in health care delivery should be defined and involving them in TOT.'s and either IEC. activities related to RCH.,

ix) Budgetary support for RCH should be increased to meet the staffing and facility gaps and the essential services package.

x) The criteria for annual funding should be based on the performance and local area needs.

II. Social Aspects:

i) " Link workers" to be used for expanding the IEC. network.

ii) 'Change agents' should be identified in each community and involved to ensure community participation at all phases-planning, implementation and evaluation of RCH. services.

iii) Wide network of informed 'leaders' (eg., panchayath members, opinion leaders) to be established through interactive sessions at various levels:

iv) Family should be the unit for taking up IEC. activity/decision making.

v) Indigenous health care providers (including traditional healers) should be encouraged to participate in the IEC. activities.

vi) Appointment and posting of health care providers at the village/sub-centre level should be subject to the approval of the local community;

vii) Adequate housing facility, social security should be provided to enhance the efficiency and job-satisfaction of peripheral health workers.

III Goals of RCH and indicators for evaluation:-

- The number oriented demographic goals (especially method specific targets) should be replaced by performance measures, viz., indicators which would reflect the ground reality of client satisfaction, quality of care and extent of coverage with essential reproductive and child health services.

Goals Of RCH:

1. People will have the ability to reproduce as well as regulate their fertility.
2. Women will be able to go through pregnancy and child birth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being.
3. Couples will be able to have sexual relations free of fear of pregnancy and/or contracting disease.

Indicators:-

Suitable indicators for performance measures would be (at the peripheral and PHC. level):

i. a) Number of institutional deliveries/1000 population.

   b) Percent. of institutional deliveries/total deliveries.

ii. Percentage of deliveries conducted by trained persons.

iii. Percent of babies with birth-weight 2500g. and above.

iv. Percentage of "AT RISK" mothers/children referred to higher level (SC/PHC/FRU).

v. No.of functioning women's groups/youth groups in the area.

vi. Percentage of couples adopting a small family norm(with effective method of spacing/ limiting family-size).

vii. Percent. (among male, married adults) of male adopters of F.P. methods - Nirodh, Vasectomy.

viii. Percentage of lactating women who breastfed their infants exclusively upto the age of four months.

ix. Percentage of under five children with diarrhoea receiving ORT at home or in the village.

x. Percentage of under-five children whose weight for age is on 'Road to Health'.

xi. Percent. of women and under-fives children totally immunized.

xii. No.of women and under-fives attending MCH sessions, regularly.

xiii. Availability and off-take of socially marketed oral pills/Nirodh/ORS-packets.

ix. No.of NGO's participating actively in RCH activities in the PHC/SC. area.

xv. Percentage increase in the demand for FW and MCH services in the area over the previous month/year.

(3) The Role of Health Promotion and Education in RCH were discussed and the following suggestions were offered

A. Identifying IEC. Activities for the target audience:

All IEC. activities should be centred around the educational objectives such as -

(i) having equitable and responsible sexual relationships and fulfilment etc.,

(ii) having the desired number and timing of children: and

(iii) avoiding illness/injury/disability related to sexuality and reproduction.

The target audiences identified are:

Policy makers, health care providers, consumers and social support system.

Policy Makers:

Conduct of workshops, seminars etc., to demonstrate the cost-benefit of interventions, showing that improvement in reproductive health leads to reduction in morbidity and mortality and promotes overall health and development. Lobbying also could be a useful technique in case of legislators.

Health Care Providers:

Seminars and workshops (interactive sessions) should be held for district and local health workers, community level health agencies and NGO's as well as indigenous practitioners and other developments workers.

The health care providers' attitude should be changed towards their client about informed choice and consumer (client) responsibility. He should also be able to co-ordinate with other agencies.

Consumers:-

The enabling activity for the client (consumers) would be appropriate selection of RCH services at reasonable cost, accessible hours and minimal waiting time. The media used might include folk media, multi-media, child-child, youth-to-youth programmes etc.,

Social Support System.

A social support system activity might be recognition for innovative community approaches to promote RCH at the local, district, national or international level.

- The IEC. activities have to be monitored at PHC and district level by the NGO's, as well as, Govt. agencies; CME. activities to be undertaken by professional bodies and teaching institutions with Co-operation from NGO's.

B. Analysis Of Needs Of Individuals And Community.

Identification of needs is to be done at Community level by the health personnel. The analysis is to be done as to which are the unmet needs, perceived and expressed needs etc., The main aim of health education is to create demand generation for services, making the clients aware of and express their needs.

The demand generation for RCH services could be accelerated by educating (improving literacy) empowering (by ensuring equal status) and enabling (through formation of Women's groups etc) the women and the adolescent girls.

C. Social Skills Required For Health Workers And Change Agents:

Interpersonal Approach, Health Worker/Change agent should follow '**mutual confrontation approach**' with empathy, support, collaboration and confrontation (i.e.., questioning system, rules, tasks etc.,)

The health worker should have skills to practise all the ten basic principles of '**effective human relation technique**'. He should be able to understand the culture, develop adequate skills in leadership and communication, conduct group discussions and come out with innovative ideas.

For this, Training of trainers (TOT) should be taken up on priority basis and re-orientation of health personnel at various levels should be taken up with hands-on training in the field.

D. Role Of NGO's vis-a vis Government Agencies

All health related institutions should take up IEC activities related to RCH. The role of NGO's should be complimentary to, but not competitive against Governments organisations. The aims and functional objectives of NGO's should have a services network in the area to be served. Their role is important in taking up innovative projects and ensuring community participation. Independent evaluation of functioning of NGO's as well as Governmental organisations is necessary so that mutual trust, which is the basic need for co-operations between Governmental and NGO agencies, could be established.

Thus, the workshop provided a good learning experience and a forum for scientific expression and sharing of experiences amongst health and medical professionals the State. The detailed report of the workshop is available on request from the authors.

NOTE: Full report is available on request from the authors.

ABSTRACTS

HALL - I : KIMS Auditorium

Thematic Papers (Staff)

Chairman:-

Rapporteur:-

Mortality from Malaria : A Logistic Regression Model

Suraj K.P, Shetty K.R and Rajeev A.
Department of Medicine and Community Medicine.
KMC, Mangalore - 575 001.

Malaria devastated the armies during II World War and after the war it devastated the population which was reeling under the aftermath of the carnage. The only light at the end of the tunnel was the mass manufacture and accelerated field trials of life saving drugs like chloroquine and mepacrine etc. Quinine which demonstrated its failure in suppressing the attacks of Malaria in soldiers and caused Black water fever, however came back after the war to replace its major contendor, Mepacrine (Quinacrine) as choice of drug for resistant falciparum attacks. Later, WHO Malaria control campaign eventually succeeded in controlling the growth of the menace in the 60s and 70s. However 1990s are seeing a resurgence in Malaria morbidity and mortality in India and the SE Asia region with major pockets in urban areas.

The rising epidemic is also accompanied by rising number of avoidable deaths as a result of neurological involvement of the parasite and other factors. A study was done on 100 cases of Malaria admitted in 2 teaching hospitals during 1996 to find out the mortality and complications due to malaria. A logistic regression model was fitted with variables like age, severity of symptoms, parasite species and treatment on the final outcome. The findings demonstrate ourlack of adequate understanding regarding the complexities of Malaria. The comparisons with historical facts and the conclusions therein will be presented.

Paper presentation By : ***Rajeev. A.-Oral***

"In depth study of reporting system-Experience of Clinical Section of Lady Willingdon State T B Centre, Bangalore."

Dr. H. Junjanna, Dr. B.Y. Nagaraj
Lady Willingdon State TB Centre, Bangalore - 4

State and National reports are prepared for the Tuberculosis programme based on the reports received from gross root level functionaries like Dispensaries, Primary Health Centres etc. Many a time these reports become discussion documents for remedial measures, for the programme and for revising the National Policies are stressed at every level. Lady Willingdon State T B Centre, Bangalore, prepare the periodic reports for the State based on the reports received from Peripheral Health Institutions and its Clinical section. To

study the valadity of reports for better understanding the Lady Willingdon State T B Centre analysed the Annual Reports for its Clinical section for five years-1991 to 1995. This analysis revealed some striking factors which need discussion. This paper discusses in detail these factors which need close look into the functioning and reporting of peripheral health institutions which are the components of District Tuberculosis programme."

Paper presentation By : ***Dr. Junjanna - Oral***

DOTs : A new approach in the Treatment of Tuberculosis.

Dr. M. Hafeezulla,
Senior Specialist, Lady Willingdon State T B Centre, Bangalore.

The Fight against T.B. Started with the isolation of tubercle Bacille by RobertKoch in 1882. The fight against TB has gone through many thrilling stages from the days of lung collapse to the advent of Rifamycin. We have gone long way. But Tuberculosis continues to kill millions of people especially in the developing countries.

The present Practice of Domicillary treatment where in the Patient is given medicine for one month has not achieved the desired result.

Hence a new approach DOTS (Direct Observation Chemotherapy Short Course) recommended by WHO whereDrug is administered to the Patient by Drug provider thrice a week. It has been successfully tried in some of the African Countries.

In Karnataka it is being implemented in six Districts from this year.

Paper presentation **By : Dr. M. Hafeezulla - Oral**

Re-emergence of Plague - 1994. The Bangalore Experience.

B.J. Mahendra and M.K. Sudarshan.
Department of Community Medicine,
Kempegowda Institute of Medical Sciences, Bangalore-560 004

" During September - October 1994 (1 month period) totally 71 patients suspected of plague were admitted to Epidemic diseases hospital, Bangalore. Of these only 17 (24 %) were "Probable cases" confirmed positive by Passive Haemagglutintation test (PHA) by NICD unit at Bangalore. The mean age of positives was 25.9 years and 15 (88 %) were males. The pneumonic plague were 10 (59 %) and the bubonic type 7 (41 %). The main symptoms were fever (76 %), cough(47 %) and haemoptysis(23 %). Lymphadenopathy was seen in 7 (41 %) cases and 2 (12 %) were asymptomatics, Only 5 (29 %) patients gave history of travelling to epidemic areas of Gujarat and Maharashtra recently.

The treatment given consisted of Inj. Streptomycin (94 %). Tab. Tetracycline (94 %). Tab. Co-Trimaxazole (11 %), Cap. Doxycycline (15 %) and Inj. Gentamycin (5 %). The mean length of hospital stay was 6.5 days and there was no case fatality. The contacts Viz, the hospital staff (n=55) were on Tetracycline chemoprophylaxix. used personal protective measures like Face Mask. Gloves and were belatedly given I dose (1 ml) of plague vaccine (Haffkine, Bombay) on 13th October. A survey of 25 families (180 persons) living in the

ED hospital campus revealed that none took chemoprophylaxis during this period. Incidentally none of the hospital staff and people living in the campus suffered from plague. A few issues and concerns pertinent to reemergence of plague (after many decades), its management and control are outlined."

Presentation: **Dr. B.J. Mahendra - oral**

Social Dimensions of Leprosy.

Dr. V.B. Patil
Lecturer, J.N. Medical College, Belgaum.

"Leprosy is described as a `Social Disease'. The term Social means living in communities. Dimension refers to an extent of the situation. It is recognised today that ill health is the product not only of germs, but also of the subjection of human organism to bad social conditions. In veiw of this, the following dimensions of Society have a definite bearing on the persistence of leprosy.

1. Familial: Arrangement for marital relations of adult members is problematic for the heads of the households. In case of deformities more grave is the problem. The impact is more so on feminine gender.

2. Educational: Separate sitting arrangement in Schools results in mental agony. Some times the students are compelled to leave their schools.

3. Economic: No gainful employment for deformed persons. If the bread-winner of the family happens to be a chronic case of leprosy the whole family life is paralysed.

4. Societal : Reaction of the Society towards leprosy patients is inhuman. They are socially ostracised. Some people have a tendency to hide the disease.

5. Religious: Recent literature on the mode of transmission of leprosy related places of public worship those that are surrounded by leprosy beggars, as the fertile field for infection to occur. Devotees may get infection if they have bodily cuts and scratches.

6. Legal: Though the Leprosy Act, 1898 is repealed, both the Hindu Mariiage Act and the Muslim Personal Law recognise leprosy as a ground for seeking dissolution of marriage.

There is a declining trend in Leprosy cases all over the world which is a sign of healthy society.

Besides other measures of prevention the following three interventions deserve special attention. (1) Total coverage of the community by way of health education. (2) Strict implementation of the Beggary Prevention Act by all States. (3) The practice of the concept of total rehabilitation.

The Celebration of W H O Day 1997 - "Emerging Infectious Diseses". Global response - Global alert" will be more meaningful if social aspects of leprosy are taken note by all those who are linked with anti-leprosy activities".

Presentation: **Dr. V.B. Patil - Oral**

Dengue Hemorrhagic Fever/Dengue Shock Syndrme

Dr. Sanjiv Lewin MD, DNB., Dr. Swarna Rekha. MD,
Dr. S.D. Subba Rao DCH DNB
Department of Paediatrics
St. John's Medical College Hospital, Bangalore - 560 034.

"Dengue has been in the news recently with outbreaks St. John' Medical College hospitals, paediatric department had announced the possibility of Dengue Shock Syndrome as long back as 1991 and has been regularly diagnosing and confirming Dengue since then.

Unpublished data from the institution shows 6 % Mortality in children who were in the age group of 1-11 years. Confirmation of Diagnosis was done with support of NIV Bangalore unit female propondence was not seen, presentation was acute fever 5-7 days duration, 84 % had history suggestive of bleeding, 71 % vomitting, 61 % altered Seniorism, 35 % seizures and 26 % abdominal pain.

Clinically fever was seen in 100 %, 48 % had heptomegaly, 35 % had skin bleeds, 6 % had splenomegaly, and ascites was seen in 10 % of the patients, 6 % had no recordable BP and 19 % were hypotensive.

As per WHO criteria 10 % of patients belonged to grade I, 61 % to Grade II, 14 % to Grade III and 6 % to Grade IV.

All patients had thrombocytopenia and elevated transaminase 88 % had hyponatremia, 65 % had evidence of DIC haimo Concentration was seen in only 23 % of the children, 74 % of the children had Lamellar pleural effusion.

Vital diagnostic indicators could be a well child with acute febrile illness presenting with bleeding manifestations and vomitting, lepatomegaly, skin bleeds with the positive investigative finding which include elevated transaminase hyponatremia, elevated PT/PTT and Rt sided Lamallar pleural effusion.

Good prognosis is seen with aggressive Management and given the worsening scnario early diagnosis and treatment make a difference in individual case management.

Presentation - **Dr. Sanjiv Lewin - Oral.**

HIV / AIDS Education : Integration into the formal School system.

Dr. Latha Jagannathan
Bangalore Medical Services Trust. (TTK)

HIV / AIDS Education and allied subjects include Reproductive System and Reproductive Health. Sex and Sexuality, STDs. Pubertal changes, Sexual abuse, Gender bias, Substance abuse, Blood safety etc., and cannot exist as an isolated chapter in Biology in High School.

More importantly, Values and Life Skills also have to be imparted to give the child a holistic education. Our aim should be towards developing the personality of the child so that he /she is able to not only identify risk behaviour but also actively say NO to any or all

forms of risk behaviour. The education system would have to work in tandem with parents to empower the child to make informed choices.

Recognisisng the requirements for the incorporation of the mentioned concepts into the formal school curriculum. a 1-day State level workshop was organised by the State Aids Cell and DSERT, 27th March 1997, from which the following recommendations emerged.

* It was felt that the Reproductive system, Pubertal changes, Substasnce abuse, Blood Safety, HIV/AIDS, STDs. and Sex & Sexuality should be included in the Biology text book from Std. 6 onwards. As a comprehensive revision of the textbook would take time, it ws recommended that this information might be brought out as a supplement to the Biology textbook.

* It was unanimously decided that both in-service and pre-service teachers should receive traning in this regard.

Accordingly, the supplementary booklety has been drafted, in addition to which, a Teacher's Manual has been devised, that contains additionsl information on Reproductive health. Substance abuse, HIV / AIDS, STDs, Child Sexual Abuse etc. As `Values' and `Life Skills' cannot be incorporated into the supplementary text, they have been included in the Manual.

The exercises and suggested activities enumerated both in the booklet and manual do not require more than a black board, chalk, pencil, and paper. Audio-visuals could be developed at a later stage.

Every effort has been made to ensure that the inclusions do not increase the burden on the teacher or the pupils.

Presentation : **Dr. Latha Jagannathan - Oral.**

HALL - II

Free Papers (Staff) - KIMS Community Medicine Seminar Hall

Chairman:-

Rapporteur:-

A Community based study of cost of morbidity and Health action in a Rural area (Tumkur Dist)

Dr. Y. Chandrashekar
Professor of Community Medicine, Sri Dervaraj Urs Medical College, Tamaka, Kolar.

A Population based study of morbidity and health action pattern was taken up at Arakere village, five kilometers from Tumkur City, with a total population of about 1100, during August 1994. The study population was subjected to interview and physical examination by house surgeons, after standardization of procedure, and questionnaire. The salient findings which are discussed in this paper are:

- Point prevalence rate of nearly 10% with higher prevalence rates reported among the under fives and 45 years and above age-groups;
- The morbidity rates, apparently varied among various socio-economic Categories
- The average (estimated) cost per episode of illness (overall) was Rs. 38.30 for consulation and drugs;
- Further, due to illness, the households incurred indirect cost, ie., on average, 3-4 days' wages, in case of poor families, also.

These, and other aspects of burden of disease and health action of episodes, especially, the fact, that least expensive health action is preventive care, are highlighted in this paper.

Presentation : **Dr. Y. Chandrashekhar-Oral**

An Epidemiological Study of Hypertension in Rural Field Practice Area of J.J.M. Medical College, Davangere.

Dr. Dayananda M.
Lecturer, Dept. of Community Medicine, SDUME, Kolar
Dr. A.H. Suryakanth
Professor and HOD of Community Medicine,
J.J.M. Medical College, Davangere.

A survery was conducted from May 1993 to Feb. 1995 in the Five villages coming under field practice area of J.J.M. Medical College, Davangere, consisting of 7873 population aged above 20 years.

The objective of this Epidemiological study was to find out prevalence of Hypertension in that area and also various other risk factors involved in the natural history of disease.

Out of this population, 65% were screened for the evidence of Hypertension by adopting the formula of Rodney D. Johnson using mercury sphygmomanometer. Door to door survey was under-taken.

The coverage in males was 69.5% and females 61%. The prevalence of Hypertension was 68.5 per thousand population, Prevalence was maximum in those over 60 years of age.

Prevalence increased significantly as age increased. It was more in females (70%) than in males (67%). In the younger age groups the prevalence was slightly lower in females than males.

The various Epidemiological factors like Socio-economic class, marriage, heridity, type of family, obesity, activity, alcoholisam, smoking and consumption of salt, are discussed in the paper.

The influence of stress (Taylor), anxiety (Hamilton) were also studied by using score method.

In this study 40% have been diagnosed earlier and 36.9% were on regular treatment.

Ignorance, negligence were major reasons for not seeking regular treatment.

Health education, follow up, and referall services to be provided at grass root level.

Presentation : **Dr. M. Dayananda - Oral**

An urban and a Rural School Health Profile

Dr. K.N. Prasad Asst. Professor,
Dept. of Community Medicine KIMS. Bangalore-4

A study on health profile of school children was carried out in an urban and a rural school in Bangalore District. The total number of 608 (Urban-305 and Rural - 303) school children were examined. The boys (288) and girls (320) were in the age group of 6 to 12 years. The Body Mass Index (BMI) of children was observed to be less than 0.15 in 74 and 90 percent in urban and rural schools respectively. The overall morbidity was high among rural school children. The prevalence of anaemia (clinical assessment), worm infestation and vitamin 'A' deficiency were found to be 6.2, 7.5 and 53% in urban school children and 8.3, 33.9, 11.6% in rural school children respectively. Dental caries is a major problem in both the schools (urban 40% and rural 30%). The morbidity conditions of skin, ENT and Respiratory tract were found to be present in 24.9, 3.6, 18.4 and 10.6, 23.1, 20.3, percent of urban and rural school children respectively. Treatment of nutritional difficiencies, minor ailments and regular health monitering should be emphsised more stricity in rural schools to improve their health status.

Presentation : **Dr. K N. Prasad - Oral**

Management of Medically Un-Explained Symptoms in Health Care: Emerging Trends.

Dr. C.R. Chandrashekar
Addl. Professor of Psychiatry NIMHANS. Bangalore.

Epidemilogical studies reveal that 30 to 35% patients who seek medical help, have medically unexplained symptoms like multiple aches and pains, weakness, fatigue, persisting pain like headache, backache or chest pain, insomnia, gastrointestinal or uro-genital symptoms, dizziness etc. All of them believe that they may have some serious physical disease. They force the doctors to investigate them, prescribe tonics, appetisers, injections. They do not accept the fact that they do not have any physical deficit or disease. They get upset if they are told that their symptoms are psychogenic. Studies reveal that they actually suffer from depressive disorders or anxiety disorders or somatoform disorder.

As mental disorders carry severe social stigma and mental health care services are not available, it is said that persons who have disabling psychosocial stressers, prefer to somatize their distress. The sickrole with bodily symptoms help them to get attention, sympathy and concessions from others. The sick role gets support from medical personnel, high-tech laboratories and drug industry.

A multi centered international study on somtoform disorders by W.H.O. reveal that somatization is prevalent both in Castern and Western cultures. 75% of these patients are females, in their 40s, and has an average schooling of 7.6 years.

In Bangalore, patients who came to PHC and G.H.C. centers with medically unexplained symptoms were studied. 65% were females, mean age was 41 years. education was 4.5 years of schooling, average number of symptoms was 13 as against 11 in USA, 23 in Italy. Bachache (68%), painful limbs (65%), painful joint (58%), weakness (43%) were the comon symptoms. They attributed these symptoms to excess heat or cold, loss of semen, white discharge, sanni, maddeedu (slow poison), witch craft, daatu (stamping the materials used for witch craft). bhattibiddide (displacement of internal organs), grahachaara (un-usual movement of planets in their horoscope), bad or weak or less blood, weaknerves.

As part of management, these attributions have to be identified and explained. Their complaints have to be listened to carefully with empathy. Unnecessary investigations and referrals have to be avoided. They have to encouraged to talk about the psychosocialstressors. Their coping skills have to be improved by counselling. Appropriate use of antidepressant and anxiolytics help the patients to feel better. The details are discussed in the paper.

Presentation : **Dr. C.R. Chandrashekar-Oral**

Assessment of Community Attitude Regarding Services of Primary Health Centre

Dr. N.C. Ashok, Dr P. Shivashankarappa, Dr. B. Prakash, Mrs. Vani Nagarj.
Department of Community Medicine
J.S.S. Medical College S.S. Nagar, Mysore - 570 015

Primary Health Care is rendered through Primary Health Centre all over India. For

successfullenss of any programme, Community participation is an essential element. In evaluation of PHC functions, one of the criteria for evaluation which can be used is community opinion about the function of PHC. Hence an attempt is made in this study with the following objectives

a) To assess the utilization of Health services of PHC
b) People's attitude about working of health team in PHC
c) People's expectations from PHC

The study included a sample of 252 houses selected by Random Sampling in the Head Quarter Village of PHC Yelwala. The data was collected by using closed structured questionnaire any by interview method. The study showed about 52.8% of respondents utilised services of PHC. Awareness regarding registration of Antenatl cases was 89.7%, followed by awareness of Immunisation (74.2%). Non availability of medicines & poor attention by Doctors made people to be dis-satisfied about the function of PHC. People expect free medicines & emergency services to be made available at PHC.

Presentation : **Dr. N.C. Ashok-Oral**

ICDS-an MIS case study

Ms. Vyshai R. Management Consultant
Dr. Girish N. PG Student , MSRMC, Bangalore-54
Wg. Cdr. Babu, Director ITM, Bangalore
Dr. Shivaram, C. Principal, MSRMC Bangalore-54

The ICDS scheme of the Government of India, launched on the 2nd October, 1976, is one of the largest Social Welfare measure across the globe. There are nearly 3 lakh Ananawadi centers as on 31-3-97. This itself produces a great strain on the Administration and Management. The current study undertaken as a part of Term Paper in MIS for the MBA Programme looks at the ICDS scheme from a managers perspective. The working of the ICDS is considered herein as running a Business Organisation; whose motto is to run the business and not give reasoms for failure. Integral to this working is the Information system. They study indentifies the bottlenecks in the data gathering, analysing and utilizing operations in the different strata of the ICDS scheme. An attemp is made to provide a feasible solution to the problems being faced and also evaluate the role of Computers in this vast organisation.

Presentation : **R. Vyshali-Oral**

The Worksite and Hypertension

Dr. M.V. Prabhu, *Professor of Medicine*
K.M.C. Mangalore.

The present study was conducted at 3 work sites, in Mangalore City during 1991-92.

The Screening for Hypertension, was carried out among 501 employees, from the 3 work sites, which included public works Department (158 Nos). Post Office (184 Nos) and 7 Bank Branch Ofices (159 Nos)

The subjects were considered Hypertensives, if the average of last 2 of the 3 readings,

either systolic BP ≥ 140 mmHg or Diastolic BP ≥ 90 mmHg. and if the subject was on Antihypertensive drugs, at the time of the study.

The Body Mass index,was calaculated by recording height and weight. Mid arm circuference (MAC), was recorded to assess fat distribution.

The association between work site Blood pressure and Bilogical Variables, occupationel status and marital status were studied.

Statistical methods, included in the study were Statistical Package for Social Sciences PC programme (SPSS) and Association and Correlation (x^2 and pearson's 'R' Test).

The study revealed that work site blood pressure was positively coorelateal with age, body mass index and mid arm circuference.

Hypertension, was found to be more, among Males, as compared to Females.

Among different occupational groups, prevalance of Hypertension was highest amongest professionals.

Presentation : **Dr. M.V. Prabhu - Oral**

PULSE IUD PROGRAMME IN KARNATAKA

Dr. G.V. Nagaraj
Addl. Director (Family Welfare), Karnataka

Family Planning Programme (renamed as Family Welfare in 1978) has had a single objective for nearly 30 years to reduce fertility as quickly as possible.

As a result of implementation of this Programme, tangible results have been achieved as revealed by the following vital indicators.

	1970	1995
Crude Birth rate	33.0	24.2
Infant Mortality rate	101.0	62.0

However the decine in Crude Birth rate by 8.8 only, in 25 years has been considered as very low by the Population Scientists.

Analysis in contraceptive practice has indicated disproportionate percentages in method mix as follows:

Sl. No.	Method	1991-92	1995-96	%
1.	Sterilisation	40.0	44.9	79
2.	I.U.D.	6.1	7.6	14
3.	O.P. Users	1.8	2.3	4
4.	C.C. Users	1.2	1.9	3
	TOTAL	**49.1**	**56.9**	**100.00**

Nearly 80% of the contraceptive practice is contributed by sterilisation alone (98% female) and mere 20% by spacing methods (of which 14% by IUD).

The National Family Health Survey (1992-93) has revealed that 18% of currently married women have an unmet need for family planning 12% for spacing births and 6% for limiting the number of births.

Crude Birth rate in Karnataka continues to remain high since the practice of spacing methods has been low.

Having realised the importance of spacing methods and encouraged with the tremendous response of the first year Pulse Polio Immunization Programme, Pulse IUD Programme was taken up as a trial in March 1995 and October 1996, wherein a good response was observed and also Karnataka stood in one of the top ranks in IUD performance at National level.

Encouraged with these two trials, for the first time in the country, Pulse IUD Programme was launched as a regular feature in Karnataka to be taken up once in 6 months. To start with March 13th & 14th as the first round of the programme.

The Pulse IUD Programme is a simultaneous mass insertion of Copper "T" to eligible married women to prevent unwanted pregnancies. The programme is planned to be implemented in the entire State twice a year during peak demand period. March 13th & 14th and October 8th & 9th have been identified as Pulse IUD Programme days during 1997.

The following programme contents have been spelt out. The objective, Technical aspects of Copper "T", Action, Plan, Environment Building, Planning of the sessions, Estimated level of acceptance, Followup, Monitoring & Evaluation.

Ist round Pulse IUD Programme was launched on 13th & 14th March 1997. Wide publicity was given by arrnaging press meet with the Hon'ble Health Minister, through All India Radio and Doordarshan. The interview with the Additional Director (FW&MCH) was telecast in the National News on 13th March at 9 PM.

45506 IUD's were inserted on these two days, 89.1% of them having 2 and less children and 67.7% below 25 years and another 27.4% between 25-30 years.

The programme was highly successful.

Presentation : **Dr. G.V. Nagaraj - Oral**

SPECIAL SCHOOL HEALTH PROGRAMME

Dr. Radha R. MD.
I/C Deputy Director (MCH), State Family Welfare Bureau, Bangalore

A new initiative of Health check-up programme was taken up by Government of India between 22nd and 27th July '96 throughout the country. The programme was implemented both in rural and urban areas for all primary school children upto 4th standard.

Out of 55 lakh students estimated 39.95 lakh (72.6%) were examined. 21.95 lakh students (54.94%) were found defective and suffering from common illness.

A lot of effort went into publicity in the form of TV fillers, newspaper advertisements and posters to create awareness among students and the general population. Done for the first time, a programme of this nature has thrown light on the magnitude of illnesses found among school children and the remedial measures to be taken.

Referral linkages of a curative nature were strengthened in this programme By sensitising this group it will help us carry on other mass programmes like Pulse Polio Programme, Measles Eradication etc.

The common illnesses detected were:

Anaemia (13.20%), Worm ingestation (8.94%), Night blindness (4.22%)
Iodine deficiency (0.12%), Ear discharge (2.46%), Visual defects (1.21%)
Scabies (1.84%), Pyoderma (2.16%), Dental problems ((17.80%)

Presentation : **Dr. Radha R. - Oral**

HALL - III KIMS AV Room

Thematic/Free Papers - Post Gradutes/Interns/ Students

Chairman:-

Rapporteur:-

The need for Targetted Information Capsules in sex Education

Dr. Girish N. PG Student, Dept. of Community Medicine
M.S. Ramaiah Medical College, Bangalore - 54

Dr. Gopinath. Professor of Community Medicine
Dr. B.R. Ambedkar Medical College, Bangalore

Mr. Narasimha Murthy N.S. Dept. of Community Medicine MSRML
Associate Professor in Community Medicine, MSRMC, Bangalore - 54

Dr. Shivaram G. Dept. of Community Medicine MSRML
Principal, MS Ramaiah Medical College, Bangalore

The students from Bangalore University affliated co-education colleges who have just completed their II year Pre University Course and in their I year of study in Diploma/ Degree are included in this study.

The study was undertaken as part of the Dissertation work for the award of Masters Degree in Community Medicine.

From among the different streams of study in different co-edication colleges in the city of Bangalore, 699 students were administered the Pretested Standardised Questionnaire under active supervision.

The questionnaire contained 5 sections viz., General Information, Specific information, Anatomical knowledge, Non-anatomical knowledge and Attitude questions.

The mean scores for the Anatomical Non-anatomical and Attitude for the Medical and Dental students are above the overall average. Commerce students are at the bottom. The Engineering stream is placed just above the average scores' while the Nursing and Pharmacy streams are placed below the average with the Science and Arts stream trailing behind them.

The Medical and Dental stream of students may be placed higher above being more knowledgeable and with a rationale attitude. The Engineering, Nursing and Pharmacy students may be placed in the Good to mediacre category; the Arts, Science and Commerce students can be placed in the third group with Mediocre the Unsatisfactory Knowledge and Unsatisfactory Attitude.

The sex wise analysis showed a significant difference among the different streams of study with respect to Knowledge but not Attitude.

Presentation : **Dr. Girish - Oral**

Post Exposure Rabies Prophylaxis with Purified Verocell Rabies Vaccine : Effect of Pregnancy on Immune Response :

M.K. Sudarshan, S.N. Madhusudhana,* B.J. Mahendra,, D.H. Ashwath Narayan, M. Jaykumary, and Gangaboriah,
Dept. of Community Medicine, KIMS, Bangalore
* Dept. of Neurovrology, NIMHANS, Bangalore.

The present study was conducted to evaluate the immuneresponse to purified Verocell Rabies vaccine, PVRV (Verorab) during pregnancy. Seventeen pregnant women received post-exposure rabies prophylaxis with PVRV as per Essen regimen of World Health Organization. Likewise seventeen 'non-pregnant' women were chosen as 'controls' and were "matched" with the "pregnant women group" for the confounding variables of age, socio-economic status and number of PVRV doses (three or five) received for postexposure rabies prophylaxis. The rabies neutralising antibody response as measured by standard Mouse Neutralization Test in both the groups of women was found adequate and more than the protective level (0.5 IU/ml) from day 14 to day 365. Contrary to the Hypothesis the antibody titres were slightly higher in the pregnant women group (except for day 180) but this was statistically not significant ($P>0.2$). In conclusion, post exposure rabies prophylaxis with PVRV (Verorab) by Essen regimen was immunogencially efficacious during pregnancy and pregnancy did not affect the immunersponse to PVRV.

Presentation : **Dr. D.H. Aswathnarayan - Oral**

Problem Based Learning on using helmets for Accident prevention-the five fold vision.

Dr. M. Sundar, *Asst. Professor,*
Aradhane Srivastava, VIII term students
Askhok Narayana M.V.
Dr. B.G. Parashuramalu, *Professor*
Dept. of Community Medicine KIMS, Bangalore - 4

Under problem - based learning in the Dept of Community Medicine, KIMS, 1½ years project were given to a group of 20 medical students (VIII term) on 'Road Accident Prevention'. They indentified 'Helmet' to be their area of choice. To start with they interacted with their own friends and medical studnets within and outside the campus. A random survey (200 subjects) on various aspects of 'helmet' were done. Moreover, the group worked in liaison with 'Traffic Training Institute'. Bangalore and participated in 'Road Safety Week' in Feb' 1997. To interact with different people from all walks of life. took an opportunity in the 'MICO Carnival' (Bangalore) on accident prevention (Mar'97). These unique and wonderful experiences of young and budding doctors to be shared with one and all in the forthcoming conference would be an eye opener precisely.

Presentation : **Ms. Aradhana Srivastava - Oral**

National Family Welfare Programme : Towards a Target Free approach - A case study of Baseline situation in Two Primary Health Centres of Karnataka

Dr. Namrita Baveja, Dr. M.K. Sudarshan
Department of Community Medicine, KIMS, Bangalore - 4

The present study is an evaluation of the field-level realistic sttuation, in two primary health centres, for the launch of "Target Free Approach (TFA)" of the National Family Welfare Programme. The results revealed that except for satisfactory antenatal care, the Government Health Centres and the Health workers female / ANM were not popular and the knowledge and practice of Family Planning was poor amongst the randomly surveyed eligible couples (n=70) and mothers of infants, (n =30). Therefore, for the successful implementation of TFA, additional resource inputs we required.

Presentation : **Dr. Namrita - Oral**

Record Analysis of Suspected Rabies Cases Coming To Isolation Hospital

Dr. N. Ravishankar - Intern,
Dr. B.G. Mahendra - *LECUTRER,*
Dr. M.K. Sudarshan - *PROF, AND HOD,*
Dept. of Community Medicine KIMS, Bangalore - 4

This study was undertaken as a part of Training in Research Methodology for the Interns, An attempt was made to retrieve the records for the period 1992 to 1996 and relevent information was extracted from the records as per the predesigned pretested schedule.

- Majority of the cases were daily wage laborers/coolies.

- More than 95% of bites were due to dogs

- About 70% of the cases did not carry information regrading the fate of the biting animal at the time of admission.

- Majority of the bites were of class II

- 50% of referral was from government hospital.

- 38% of cases who were vaccinated, developed symptoms of rabies.

- Out of 39 who recovered 10.8% were class III bites, 56.4% had previously recieved NTV and 10.3% TCV.

- Out of 91 patients who recieved NTV, 13 had recieved wound treatment and 7 had recieved 14 doses of ARV and 24.2% died.

- Based on the study results certain recommendations are made.

Presentation : **Dr. N. Ravishankar - Oral**

HALL - IV KIMS Lecture Hall II

POSTER PRESENTATIONS:

Chairman:

Rapporteur:

Problem based Learning: Innovative approach in Medical Education (Two years of Experience)

Dr. M. Sundar - Asst. Professor,
T. Aparna. VIII Term Medical Student
S. Jayapradha VIII Term Medical student
Dr. B.G. Parashuramalu - Professor,
Dept. of Community Medicine, KIMS, Bangalore-4.

" Bangalore, popularly known as the `Garden City' of India is the capital city of Karnataka State (Southern India). Four medical colleges (3 private; one Govt.) have been established in close proximity to each other in a limited geographical area. These `ivory towers'. so called have been set up to provide as many Doctors to lessen the burden of health problems and to set right Doctor-patient ratio. Medical education is imparted as usual in a form of `Didactic lectures', few field based and community oriented teaching. In this background, as an `exploratory' exercise in our department, we initiated `PBL' in an unique fashion to motivate medical students, to think and act independently and understand `public health' issues and its consequences.

A cohort of 118 medical students (II MBBS) were selected in 1995. They were divided into 6 subgroups consisting of 19-20 students having their own leader and recorder of the group. Each group was assigned two years to complete their work. Later, same work would be continued further by new batch of students (juniors) after their tenure.

For each group, interesting `problem based learning' topics were given such as

Group I - Over the counter drugs
II - Child labour
iii- Prevention of Cigarette smoking
IV - Road traffic accident prevention
V - Blood group registry
VI - Hygiene of eating establishments

They were asked to formulate own short term and long term objectives and modus operandi. regular fortnightly meeting used to be held among themselves and with the faculty members.

At last, this thrilling opportunity at the end of two years gave them a lot of courage, enthusiasm, interest on public health and to participate in seminar, panel discussions etc.. They also organised exhibition, developed liasion with voluntary health organisations etc. However, students satisfaction, attitude and subsequent performance with relevant photographs and rich experience of this unique endeavor would be shared with one and all in the conference."

Presentation : **J. Aparna - Poster**

HEPATITIES - B VIRUS INFECTION - CONTROL STRATEGIES

Staff, Dept. of Community Medicine, M.S. Ramaiah Medical College, Bangalore-54.

" The multi coloured poster will deal with the Epidemiology of HBV (Hepatities B Virus) and aspects of its Prevention and Control. An attempt will be made to collate the available information regarding (i) the facts and figures (ii) Myths and controversies.

The strategies for control of HBV assume a greater significance in the context of the 1997 - World health Day Theme `Emerging Infectious Diseases - Global Alert and Global Response'. A special emphasis is to look at the (a) "Failure" to control HBV reflecting on the ? breakdown of the Public Health Measures (b) Global and local experience of HBV Immunisation strategies (c) Role of Immunisation as a Control and / or a Preventive measure.

Presentation : **N. Girish - Poster**

A Study on the impact of I.C.D.S on Nutritional Status of pre-school children in Rural I.C.D.S Area of North Karnataka.

Dr. Basavaraju, M., Prof.A.V. Kasturi, Prof L. Vijayadev
Dept. of paediatrics, KIMS, Hubli.

"The evaluation of nutritional services was undertaken in the rural ICDS Block Hubli, Dharwad district where the project is functioning since 1985. A door to door survey was conducted from March 1995 to May 1995 in eight selected anganawadi areas in ICDS block and randomly selected matched Non-ICDS rural area served as controls. The universe of the study has been 674 children of 1-6 years age group in ICDS area and 350 children of 1-6 years age group in Non-ICDS area. The prevalance of malnutrition was more in Non ICDS area (80.57 %) compared to ICDS area (76.40 %). among ICDS group grade I, II, III and IV malnutrition were 39.61 %, 32.15 %, 4.89 % and 0.75 % children respectively, where as among Non-ICDS group it was 37.71 %, 31.42 %, 10 % and 1.42 % respectively

Prevalance of malnutrition was more among children of 2 - 3 years age group compared to other age group in both ICDS and Non ICDS area.

Prevalance of malnutrition was equal among male and female in ICDS area, where as malnutrition was seen more in females in Non ICDS area. Severe grades of malnutrition (Grade III, IV) were seen more among SC, ST, B.C & Minorities compared to higher castes in both areas.

The relationship of malnutrition with respect to age, sex and caste were studied by statistical application."

Presentation : **Dr M. Basavaraj - Poster**

ASSESSMENT OF PROTEIN CALORIE MALNUTRITION AMONG THE SCHOOL GOING CHILDREN OF RAGIGUDDA SCHOOL, JAYANAGAR, BANGALORE.

Dr. Arun Kumar.S. Bilodi - Lecture in Anatomy
Dr. N. Shantharam - Professor and Head of the Department of Community Medicine.
Sri. Devaraj Urs Medical College, Tamaka, Kolar.

" Malnutrition is a predominant problem in school going children be it a rural or urban. Magnitude of problem is high among middle and low socio economic status persons.

A longitudanal study was conducted at Ragi Gudda Temple school Bangalore of school going children in the year 1993-94, 1994-95 consecutively, methodical examination of the above school children was done using pretested schedule. Standing Height was recorded to the nearest half centimeter, weight was recorded by using bathroom scale which was adjusted before recording, Accuracy of weighing machine was also checked. Chest measurements were measured. All systems of body were examined in detail. Major problems detected were sent to the hospitals for further needfull. Parents were called and advice was given to them about their childrens' health. All the above cases were followed for a period of 2 months.

Results of the study are discussed in the paper.

Presentation .: **Dr. Arun Kumar S. Bilodi - Poster**

HANDIGODU SYNDROME - THE DISEASE OF MANY QUESTION MARKS;

Miss. Rashmi Shyam,
Miss. Aradhanan Srivatsa, VIII Term Students
Dr. Gangaboriah, Dr. B.J. Mahendra,
Dept. of Community Medicine, KIMS, Bangalore.

22 years after this disease made its entry into medical literature, the Handigodu syndrome remains as much a puzzle today, as it was, then.

The disease had 75 victims in its clutches 2 decades ago & today boasts of 400 of them principally coming from 18 villages in Karnataka.

The condition, which is not fatal *perse*, affects mainly the vokkaliga and Deevaru communities and presents clinically as osteoarthritis with insidious onset Joint pains, stiffening and deformities of the hip and knee joints.

As regards the etiology, victory still continues to elude us, as the possibility of a food borne, viral, autoimmune or heriditery component, is still a matter of conjencture with all studies being inconclusive.

Presentation : **Ms. Rashmi Shyam - Poster**

LEPTOSPIROSIS - STRIKING WITH A VENGEANCE

Ms. Aradhana Srivatsa
Ms. Rashmi Shyam, VIII Term Students
Dr. Gangaboraiah, Dr. B.J. Mahandra,
Dept. of Community Medicine, KIMS, Bangalore

Leptospirosis, a little spoken of disease in the yesteryears is today demanding the attention of the medical community, especially with the surge in the number of cases, suddenly threatening to cause an outbreak.

Primarily a zoonotic disease, it spreads to human beings through contaminated water which gains entry through the oral route, nose or conjunctive.

It is a truly multisystem disease which starts as a mild undifferentiated pyrexia with a potential to cause fatal illness by leading to hepatorenal damage (Weil's disease).

The disease also manifests with purpuric hemorrhages, albuminurea and aseptic meningitis and a high degree of suspicion is required to make the diagnosis.

As the water contaminated with the infected animals excreta, has to gain entry through abraded skin and mucosa, certain occupations might be more exposed to the risk of disease eg. agricultural workers and sewer cleaners.

Thus awareness, not only amongst the laymen, but also among the medical fraternity, about the importance of protective clothing, disinfection of water, rodent control and animal vaccination, will no doubt go a long way to curb the disease.

This, we hope, will be a stepping stone towards the achievement iof that objective.

Presentation: **Ms. Aradhana Srivatsa - Poster.**

The Epidemiology and Clinical features of Dengue Virus Infections.

Kiran S. Rao. Sujith Kumar, Dr. B.J. Mahandra,
Dept. of Community Medicine, KIMS, Bangalore;

Each year 30 to 60 million cases of Dengue virus infections are recorded from around the world.

Dengue fever is caused by the Dengue virus which is a flavivirus belonging to the Group II category arboviruses. The main vector is the mosquito Aedes aegypti. However, Aedes albopictus, Aedes polynesiensis and the Aedes scutellaris complex is also known to carry the virus. The mosquito acquires the virus by feeding on a human on the day before the fever commences to the fifth day of fever (Viraemic Period). Extrinsic incubation period is 8 to 10 days. The mosquito remains infective throughout its life period.

CLINICAL FEATURES:

DENGUE FEVER (DF)

- Sudden onset of high grade fever.
- Chills.
- Intense headache.
- Joint pain.
- Lasts 5 days with complete recovery.

DENGUE HAEMORRHAGIC FEVER (DHF)

- All symptomds of DF.
- Petechiae, Echymosies.
- Epistaxis, bleeding gums.
- Haematemesis, Melena.
- Enlarged liver.

DENGUE SHOCK SYNDROME (DSS)

- All symptoms of DF and DHF.
- Hypovolaemia, cold clammy skin, restlessness.
- Narrow pulse pressure (<20 mm of Hg,.)

Presentation : **Kiran S Rao -Poster**

Tuberculosis - A Time Bomb Will AIDS Shorten its fuse ?

Aruna P.
Betoshini Chakraborty VIII Term Students
Dr. Gangaboraiah, *Asst. Professor*
Dr. B.J. Mahendra, *Lecturer,*
Dept. of Community Medicine KIMS, Bangalore - 4

This is an overview to appraise and arouse awareness regarding TB especially in view of the rising resurgence of Tuberculosis in the country. Unlike most epidemics this is not a single entity disease as its spread, morbidity and mortality patterns are enhanced by the spreading wave of HIV - It is an epidemic within an epidemic. We are making a small effort to awaken the masses and remind the medical faculty - there is a solution, there is a cure and there are resources, but what we don't have is .... TIME. It is necessary to make the people aware of TB - its mode of spread, its extent of hazard, its prophylaxis & its cure. TB-if not stopped will kill 40 million in this decade and leave no child healthy to see the next decade. It is not fighting for someone else's cause, it is our own survival. Come, let's join hands and maybe save the child to die in the never moment. Ours is an effort towards a mammoth health problem by try is all we can to fight it, cause the only other alternative in DEATH.

Presentation : **Betoshini Chakraborty - Poster**

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